

Added value or added burden? A qualitative investigation of blending internet self-help  
with face-to-face cognitive behaviour therapy for depression

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### Abstract

**Objectives:** Numerous studies and reviews have explored the value of adding therapist support to internet self-help for improving client adherence and outcomes. This study is different as it explores the value of adding internet self-help to face-to-face therapy, from the perspective of practitioners who used both. This study explores practitioners' experiences of whether - and how – internet self-help blended with face-to-face therapy may confer an added value or become an added burden to their routine practice.

**Methods:** Using a structured topic guide, we collected narrative data via 3 focus groups and 1 telephone interview from 11 practitioners across two sites in England. We carried out a thematic analysis within two domains, 'value vs. burden'.

**Results:** Practitioners reported that internet self-help can confer added value to face-to-face therapy by: fostering client engagement with face-to-face sessions; making therapy ubiquitous beyond sessions; and preventing therapeutic drift between sessions. Conversely, internet self-help can add burden to face-to-face therapy when it is experienced as disruptive, overwhelming and time-consuming.

**Conclusions:** Recognizing and mitigating factors that can turn internet self-help from an added value to an added burden will help practitioners adopt and make the most out of blended therapy.

**Keywords:** digital mental health, cognitive behaviour therapy, depression, qualitative research methods, blended approach

## Introduction

Digitally-enabled mental health care, or e-mental health, can address several areas of service delivery involving education, screening, assessment, monitoring, intervention and social support (Lal & Adair, 2014). Internet-delivered therapy is one of many e-mental health solutions that are changing the landscape of service delivery by addressing challenges associated with traditional therapy delivery, such as limited therapist resources, lack of accessibility, time pressures, stigma and high cost (Carolan et al., 2017). More specifically, internet-delivered cognitive behavioural therapy (iCBT) has been developed and evaluated for nearly two decades as a treatment for depression, in addition or as an alternative to traditional treatments for depression including medication and face-to-face psychological therapy (Andersson & Hedman, 2013).

Internet-CBT can be delivered in three main ways. First, as standalone self-help where clients work through a software-based standardised therapy program autonomously and without any support from a therapist (Gilbody et al., 2015). Second, as guided self-help, a professional provides support, usually by phone or email, as an add-on to a software-based standardised therapy program (Gilbody et al., 2017a). Third, as therapist-delivered sessions, iCBT relies on the synchronous client-therapist communication via telephone, email or via web-based “chat-rooms” to replace or support face-to-face meetings (Kessler et al., 2009; Muller & Yardley, 2011). The distinction between these three iCBT versions is not always clear, because of various hybrids of software-based self-help and therapist-delivered sessions via the internet (Ruwaard et al., 2011).

When delivered as standalone self-help, iCBT has a small effect on depression (Cuijpers et al., 2011), as opposed to iCBT delivered as guided self-help, whose effect is large and comparable to that of face-to-face therapy (Cuijpers et al., 2010). A meta-analysis found that iCBT was four times more effective with online therapist support rather than without any

therapist contact (Spek et al., 2007). Three further reviews (Cuijpers et al., 2009; Johansson & Andersson, 2012; Palmqvist, Carlbring, & Andersson, 2007) indicated that the longer the therapist input, the better the clinical outcomes with iCBT, albeit by pooling together therapist-delivered iCBT with iCBT self-help. More recent evidence indicates that the effectiveness of therapist-guided iCBT is comparable to face-to-face therapy (Carlbring et al., 2018; Webb et al., 2017).

Offering therapist support as an adjunct to iCBT self-help is also associated with higher adherence and completion rates (Cuijpers et al., 2009; Gerhards et al., 2011; Palmqvist et al., 2007). The REEACT study, one of the largest RCTs of iCBT self-help for depression, reported minimal adherence to an iCBT program and non-significant clinical outcomes comparing it to usual care, when no therapeutic support was offered as an adjunct to it (Gilbody et al., 2015); however, when telephone support was offered in a subsequent study (REEACT 2), client engagement with the same iCBT program increased and clinical outcomes were better than usual care (Gilbody et al., 2017b).

Although numerous studies and reviews have explored the value of adding therapist support to internet self-help for improving adherence and outcomes, less is known about adding internet self-help to face-to-face therapy in the context of 'blended therapy' (Kleiboer *et al.*, 2016). Blended therapy is characterized by continued therapist input alongside internet self-help to allow greater flexibility and personalization within the overall therapy process (Berger et al., 2018; Wentzel et al., 2016). A recent review supports blended therapy to be feasible and effective compared with no treatment (Erbe et al., 2017), but questions remain about its wider acceptability by therapists. Psychologists are largely in favour of blended therapy, but would like to understand better the online content, clients' perceptions and legal implications of self-help programs used alongside traditional face-to-face therapy (Dijksman et al., 2017).

A randomised controlled trial called European Comparative Effectiveness Research on Internet-based Depression Treatment study (E-Compared) – has evaluated the efficacy and acceptability of blended therapy for people with depression in eight European countries (Kleiboer et al., 2016). As part of E-Compared, we have conducted this qualitative study aiming to explore practitioners' experiences of blending internet self-help with face-to-face therapy in order to answer two main questions and two secondary questions:

- Can internet self-help confer an added value to face-to-face therapy?
  - What factors make blended therapy valuable over and above face-to-face therapy alone?
- Can internet self-help become an added burden to face-to-face therapy?
  - What factors account for blended therapy being more burdensome than face-to-face therapy alone?

## **Methods**

### **Research Design Overview**

A total of 11 Psychological Wellbeing Practitioners (PWPs) who delivered blended cognitive behavioural therapy (b-CBT) in primary-care, mental health services in the UK as part of their involvement in the E-compared Trial (Kleiboer et al., 2016), participated in this qualitative study. Altogether, three focus group discussions (n=10) (Krueger, 1994) and one individual semi-structured interview were carried out. The data analysis consisted of a deductive thematic data analysis using the discussion topic guide (Boyatzis, 1998) and an inductive analysis to elicit new, relevant codes until thematic saturation was reached (Braun & Clarke, 2006). A thematic analysis was selected due to the approach's methodological flexibility and capacity to generate a rich, detailed, and complex account of the data (Braun & Clarke, 2006).

## **Participants Recruitment**

### *Participant process*

The study was conducted within Improving Access to Psychological Therapies (IAPT) services across four sites in England. IAPT is funded by the National Health Service (NHS) and provides primary care mental health services for common mental health problems, mainly depression and anxiety disorders (Clark, 2011). Typically, IAPT services deliver two types of psychological interventions: low intensity, which usually comprises six thirty-minute guided self-help sessions usually by phone, and high intensity, which usually comprises 12 one-hour sessions of face-to-face therapy.

The participants were Psychological Wellbeing Practitioners (PWP), a relatively new workforce in the English health system established about a decade ago as a part of the IAPT initiative (Department of Health, 2008). PWPs are graduates, of any field, who attend a one-year, full-time, post-graduate course while practising under close supervision. They are characterized as a 'young workforce', whose role is to use CBT-informed low-intensity interventions to service users with mild to moderate depression and anxiety disorders through a brief-contact high-volume approach (Clark et al., 2009). PWP roles in the services that we recruited from were divided into junior and senior roles. Junior PWP make up the majority of the PWP workforce who are either in training or have limited experience and responsibility. Senior PWPs are qualified and more experienced and provide clinical support and supervision to junior PWPs, as well as carry some line management responsibilities and support the Service Lead with service developments (University College London, 2020).

As part of the E-Compared trial, the blended therapy was comprised of alternate, weekly sessions of internet self-help and face-to-face cognitive behavioural therapy for depression, totalling six sessions of each over 12 weeks. The duration of each session was flexible but it varied between 30-60 minutes. Internet self-help was delivered via an online

platform called MoodBuster, which comprises three elements: (1) a web-based interface providing access to CBT-based self-help for clients; (2) a web-based portal for therapists to view client progress and give feedback; (3) a mobile phone application for mood monitoring, as appointment reminders, and behavioural activation related activities. The online platform consists of six core modules: introduction, psychoeducation, behavioural activation, cognitive restructuring relapse prevention; and two optional modules problem solving and physical exercise.

Messaging between the practitioner and the client through the internet portal enables practitioners to motivate clients to engage with the online platform in-between face-to-face sessions and to make appointments online and send reminders about homework. However, messaging was rarely used by the therapists as they already utilised internal IAPT communication systems for messaging the service users. During the meetings with the research team the therapists stated that they thought that messaging through the MoodBuster platform would be burdensome and a duplicate effort. Automated messages via the mobile app prompted clients to rate their mood twice. Each mood scoring was automatically added onto a graph (in the mobile app) that depicted mood fluctuations throughout therapy.

The research team had planned 10-14 hours of training per PWP, however, this schedule was declined by service leads as overly time consuming and training delivery was significantly reduced to 3.5 hours in total. All therapists, most of whom had been involved in the trial from the outset (2015), received two training sessions (a) in utilising MoodBuster and (b) in techniques of blending online modules with face-to-face sessions. The training was delivered in-house at IAPT clinics and offered as group or individually for those who could not make group training. Refresher training that was offered for this purpose to all trial PWPs who did not use MoodBuster for more than 2 months since the time of their initial training, was not taken up with the exception of one therapist. Ad hoc support was also offered by the research

team throughout the trial, but again this was requested at seldom by the PWPs and almost always related to technological issues such as log-in problems.

A total of 101 service users with depression (PHQ-9 score range: 5-26) were recruited into the E-Compared trial, 43 males and 58 females. The mean age was 35 years old, with a range of 18 to 67 years old. Participants were randomly allocated to the control/face-to-face CBT (52 participants) or intervention/face-to-face and iCBT (49 participants). There were no statistically significant differences between groups at baseline for any of the measured demographic or clinical variables.

### *Participant Selection*

The PWPs whose role was to deliver blended CBT in the E-Compared study, were invited to participate in this qualitative study. These PWPs had received group and individual training and supervision, supported by electronic and printed manuals, on how to use the internet platform MoodBuster and the related mobile app, and how to blend these with face-to-face sessions. PWPs were recruited through different methods in the trial's different sites. Thus, in the South of England all PWPs that worked on the participating IAPT teams were recruited into the trial. In the North of England a selected number of PWPs were recruited by the service lead. PWPs provided treatment for both the intervention and control arm participants as individual clients were the unit of randomisation.

Out of 21 practitioners invited, a total of 11 practitioners (52%), seven women and six men, consented to participate in focus groups and interviews across 2 NHS Trusts. A total of three focus groups (two in the South and one in the North of England) were held with 12 practitioners and one telephone interview was conducted with one practitioner. The role composition of the 11 practitioners consisted of PWPs at different levels of seniority, including three at senior level, eight juniors and two trainees. Only four practitioners had a post-graduate qualification (Masters). All practitioners had been trained to deliver blended therapy and had



referred at least one person into the E-Compared study. The rest of the practitioners provided blended therapy to a minimum of one and a maximum of 11 clients. Table 1 provides an overview of the participating practitioners' characteristics.

***Insert Table 1 here***

### **Data Collection**

After giving written informed consent, PWPs who agreed to participate in the study were invited to attend focus groups in their respective IAPT services. The invitation to have one-to-one interviews, either face-to-face or on the phone, was offered as an option to PWPs who could not attend the focus groups. Discussions were facilitated by a researcher and were audio recorded and transcribed verbatim with the permission of the participants. Interviews were guided through a topic guide. Questions that were covered during the interviews are listed in the appendix. To minimise responder bias, the focus groups were organized and conducted by a researcher (JW) independent from the original E-Compared study team. Since the E-Compared team had recruited, trained and supervised the participating PWPs over the preceding 24 months, this relationship might have potentially influenced participants' responses and behaviors during the qualitative interviews (Holden, 2001). Detailed information about authors and their involvement with the research process has been provided in the appendix.

### **Analysis**

The coding team consisted of three researchers (JW, AP, AD) who familiarised themselves with the data through repeated readings of the focus group transcripts and who met regularly to develop a shared coding framework. The team carried out a deductive thematic analysis using the discussion topic guide (Boyatzis, 1998) and an inductive analysis to elicit new, relevant codes until thematic saturation was reached (Braun & Clarke, 2006). The analysis commenced by reading and re-reading the transcripts, while making notes. Data were

then coded line-by-line in search of interesting features which were coded using a systematic approach. The codes were then collated to form superordinate themes by a senior member of the team (LG). The coding framework was iteratively adjusted in order to answer the study's research questions. The final themes were then reviewed to ensure that they cohered with the overall thematic map. The themes were defined and named.

NVivo software (*NVivo qualitative data analysis software*, 2015) was used to store, index and retrieve textual material and to identify illustrative quotations, which remain anonymous and are cited with the participants' approval. The penultimate conceptual framework, with example entries, was discussed among all authors to confirm its coherence and relevance and to ensure that all final codes remained grounded in original data. The final framework was amended and re-shaped to enable the deletion of redundant codes and the merging of similar ones. We made sure that the final framework was representative of the entire dataset and that we presented at least one quote from every participating practitioner.

## **Results**

### **Added Value of Internet Self-Help for Face-to-Face Therapy**

Three overarching themes captured the value of blended therapy: engagement, ubiquity and therapeutic focus. Practitioners' experiences suggest that internet self-help can foster client engagement with face-to-face sessions because it adds flexibility and choice in the therapy process, but also because of the rewarding qualities of consolidated learning and a novel approach to therapy. Added value also stems from making therapy ubiquitous beyond face-to-face sessions: the internet program offers opportunities for reflection outside the therapist's office, as well as aiding memory and homework. Finally, the internet program can be valuable for preventing therapeutic drift in practitioners through tracking and bridging therapy content and progress from one session to another.

***Insert Figure 1 here***

**Fostering client engagement with face-to-face sessions.** The quote below illustrates the added value that practitioners attribute to internet self-help as means of enhancing engagement with the therapeutic process altogether.

*“At first I was a bit unsure how it would work and whether it would be effective but to see people engaging in it ... it did kind of change my opinion because I thought actually, you know, people are responding, they’re getting something out of this, they’re attending.*

[Participant 10]

**Flexibility.** Practitioners reported that client access to internet self-help was a great advantage that allowed them to complete the program at their own time and space.

*“The main benefit I picked up on was the fact that [...] you're not asking somebody to go into work late every single week. You're giving them that flexibility and it's their commitment in that sense.”* [Participant 4]

*“I like the ability you could send messages to the clients and they can send messages back and so on. All the tasks were appropriate for the problem, for the goal, for the intervention. The approach is good, giving flexibility to the therapist to customise the right tools or techniques in terms of what to recommend and to switch the order in it.”* [Participant 9]

**Choice.** Offering a blended approach as well as traditional therapy was considered as adding value to service provisions and engaging clients better.

*“I think giving somebody the choice and saying, you know, you’ve got this option or that option...If it was a choice-based thing then people I think would probably engage even more then”. [Participant 7]*

**Consolidation.** Practitioners linked better engagement with the therapy process to better consolidation of learning, which was achieved through the reiteration of key messages

by both the practitioner and the Moodbuster program, and through clients having twice as long to assimilate their new knowledge and rehearse their newly acquired therapy skills.

*“I think people appreciate the opportunity to actually meet their therapist and then consolidate what’s been learned. [...] Somehow the engagement seemed a bit better, and when they came back their understanding was a bit better as well, and I’d recap.”* [Participant 5]

*“I think improvement was better in the E-Compared one rather than just standard treatment because they had the extra time to practice the techniques, and it was great. I found once people had actually attended the first session they keep on going after then.”* [Participant 7]

**Novelty.** Practitioners commented that uptake of therapy was influenced by the fact that the blended approach was seen as a new development: *“...that blended development was what sold it for the client.”* [Participant 4]. It was also seen as a ‘bonus’ to traditional face-to-face therapy:

*“I think a lot of people would go for the blended because it’s something a bit different and they’re getting kind of two forms of therapy out of it...”* [Participant 7]

**Making therapy ubiquitous beyond face-to-face sessions.** Offering internet self-help in addition to face-to-face therapy was described by a practitioner as *“extending therapists’ presence ... between sessions”*. [Participant 8]

**Reflection.** Automated mood ratings were reported as valuable for encouraging reflection rather than accepting a black-or-white way of thinking.

*“...they [clients] could look back and think “okay, so that’s how this week has been”, rather than looking at it and thinking “oh it’s really bad” or “it’s really good”. They could actually reflect back and it got them thinking about it a bit more, getting those reminders. Everyone who had them seemed to like them anyway.”* [Participant 10]

**Memory aid.** Clients receiving mobile reminders as a prompt to carry out daily planned activities in-between face-to-face sessions was considered a valuable feature of blended therapy by practitioners.

*“I think... it [automated reminders] can... extend the clinical touch, out of sessions, especially by clients getting the reminder on their phone to returning to treatment in their activities, and that’s also an advantage for the client as to nudge them into doing it.”*

[Participant 9]

**Homework aid.** The blended approach also seemed to facilitate client adherence with CBT homework, which is a critical element for successful outcomes.

*“I found that actually it was good to ... give someone a worksheet for example but actually knowing that they could log onto the programme and actually use some of those tools I think made them more inclined to do the homework in-between the sessions.”* [Participant 7]

*“I think, particularly with the homework setting... even small practical issues, sort of, someone losing a worksheet or you can’t read their writing ... it kind of avoids all of that, and it’s all in one place. So it’s never a case of “Oh I forgot the homework that we done two sessions ago...it’s just nice that it’s all kind of collated and presented really well.”* [Participant 6]

**Preventing therapeutic drift from one face-to-face session to another.** Tracking: The practitioners mentioned the usefulness of the internet programme for their own practice, especially keeping them on track with client progress and focused on specific therapeutic interventions.

*“.. and I think it’s probably quite a nice way to keep on tracking as well, and quite focused on what you’re doing. Because obviously you know what module they’re doing next, you know what intervention they do ... this definitely keeps you on evidence base all the time.”*

[Participant 4]

**Bridging.** The platform not only improved monitoring of client progress but also, reportedly, had a positive impact on the practitioners' ability to connect their clients' learning from the therapy sessions with the internet platform and to enable continuity between sessions using the platform as a bridge between sessions.

*"...at the next session I would go "so did you use that? What did you learn?" so on, and then that would give me a thread to start with and further build and link my face-to-face session to whatever they did online and so on."* [Participant 8]

### **Added Burden of Internet Self-Help for Face-to-Face Therapy**

Three overarching themes capture the burden of blended therapy being disruptive, overwhelming and time-consuming. Practitioners' experiences suggest that technical problems, deviation from usual practice and dissonance with client expectations account for the disruptive element of internet self-help when added to face-to-face therapy. Burden also stems from making therapy overwhelming because of the intrusive reminders and the information overload from the internet program. Finally, burden is created because of the additional tasks and longer duration of therapy overall as a result of incorporating internet self-help in-between face-to-face therapy sessions.

### ***Insert Figure 2 here***

**Disruptive.** Technical problems encountered by clients while using the internet program, and having to be resolved by practitioners, created access and usability issues.

*"One particular client... did struggle some weeks with engaging with the programme ... it was a technical issue and that she'd forgotten her user name and she then emailed the support line and got that back. So yeah, we were able to sort of rectify that."* [Participant 11]

*"I had a few problems accessing it. I can't remember quite why, I had to go back and get a new password sometimes, or new registration, or something I can't remember using. That was a problem sometimes."* [Participant 5]

*"I had an issue where me or the client couldn't figure out why when we were putting the... activity list for behaviour activation, it wasn't saving. Then I realised that you basically have to save it twice before you come off the page... so there was a period of frustration because we couldn't figure out why it kept deleting."* [Participant 6]

**Deviation from usual practice.** Concerns were voiced about increased burden due to blended therapy being a deviation from the practitioners' usual, more parsimonious role.

*"I guess we're a bit outside of our comfort zone maybe in terms that were not, we don't sort of do it normally so yeah that might be something that's quite difficult with it, I think."* [Participant 8]

*"When you do the initial screens [interviews], the point of that is for us to determine the right service - and if so, what's the possible right intervention, and this [blended] is an intervention we've never really had to consider."* [Participant 1]

**Dissonance with client expectations.** Practitioners said that clients' expectations about therapy did not fit a blended model.

*"I found it difficult to see where it fits in terms of our treatment. We do face-to-face therapy; we also offer computerised...I found it quite difficult to define the client that I felt would benefit most from blended therapy."* [Participant 8]

*"Most people when they come to a therapy provider they expect a traditional face-to-face weekly sessions. Most people want that, because that's what they've come for in their head already."* [Participant 2]

**Overwhelming. Intrusive reminders.** Practitioners reported that there were occasions when clients found the prompts intrusive and opted out of this component.

*"I think the only problem I had - but it was completely just down to the person - they were getting those reminders through about rating their mood, and...found them really*

*irritating and a bit invasive, and it was going to potentially cause them to disengage from it."*

[Participant 8]

**Information overload.** The comprehensive nature of the internet self-help program was somewhat contrasted with the "lean" CBT approach adopted in low intensity interventions as delivered by the participating practitioners.

*"It went against what we know in terms of the CBT; the evidence is that you do one thing well... ..whereas with this you did every intervention well, and it was quite heavy and burdensome in that sense. Whilst I thought the actual programme was fantastic, and it was aligned with NICE guidelines, and evidence in that sense, to actually do all of it with just one client, felt quite heavy."* [Participant 4]

**Time-consuming. Additional tasks.** Burden was often linked with the way service provisions were set and the clinical targets that each practitioner had to achieve. To assure intervention fidelity across practitioners, they were asked to complete a short form after each face-to-face session. This was described as an added burden to practitioner workload. The practitioners reported that the rigidity of the internet program added to the time demands because practitioners were not able to use their discretion to alter the course of the therapy.

*"I was just gonna say we had to write about each person afterwards and how each session, that was quite laborious."* [Participant 5]

*"And that concept is when you've done certain modules sometimes meant you did certain modules that weren't relevant, to unlock the relevant ones."* [Participant 4]

*"I had someone (trial researcher) come in once to show me how to use it (MoodBuster) when we first did it. It wasn't like until two months later (I recruited) someone on the programme, I forgot how to use this programme, I had to go through all the sheets."*

[Participant 2]



**Longer duration.** The practitioners fed back that the high number of sessions offered in the blended intervention did not fit with the brief nature of low intensity interventions within IAPT services. As a result, taking on client for blended therapy created a backlog because therapy took longer to finish. Longer duration was also a burden for clients according to practitioner experiences, who struggled with the concept of having 12 instead of 6 sessions of the same therapy (CBT) for the same problem (depression).

*"I had one client on it, and the main drawback for me was that you did six face-to-face and six online, now that's 12 weeks. Normally a client would only be on your caseload for six weeks. One of your pointers here is the burden on therapist's time...Seeing clients allocated to the blended therapy ... increased my waiting list significantly and that did put me off putting anyone else on it [inviting clients into the study]" [Participant 4]*

*"I remember one client in particular couldn't get her head around it and said, 'So that one is six sessions, but this one's 12, so can I just get better with the six?'..." [Participant 3]*

*"...the first sessions being longer affected your workload, took a little bit longer doing like fidelity forms and stuff after sessions - that wasn't really factored into our week, so it was us just having to find the time to do stuff like that. [Participant 8]*

### **Discussion**

The therapists' discussions highlighted the importance of achieving the right balance between the perceived burden and the value of an intervention. When the burden is perceived as higher than the value the intervention comprises it is less likely for the approach to be utilised. Thus, therapists who held unfavourable preconceptions about the blended therapy found it more challenging to recruit into the trial and to provide the intervention compared to their counterparts who were more positive about the approach.

The traditional training and role of a PWP with IAPT services is limited to just being a coach who uses standardised, manualised interventions (Turpin, 2010). This is in contrast to

the role of a clinical or a counselling psychologist who employ a more diverse approach to therapy. The blended approach for E-Compared relied on the PWPs autonomy and flexibility in tailoring therapy sessions to each client's needs. However, PWPs found this component challenging and anxiety provoking. This may be related to their limited experience (Green et al., 2014), considering that their clinical practice ranged between 12 and 53 months. Therefore, it is not surprising that some PWPs regarded the blended intervention as not in line with their role and beyond their competences. This raises the question whether PWPs are the most appropriate workforce to provide this new intervention, and whether the blended approach is actually more suitable to be applied by more experienced therapists at a higher step of service delivery.

Our findings appear to align with the literature on therapist attitudes, perceptions and experiences of blended iCBT. One study suggested that the use of an iCBT platform increased therapists' skills by providing structure to therapy (Månsson et al., 2013). These reports appear to complement our findings in relation to the added value of ubiquitous therapy, where features such as reflection, memory and homework aids, otherwise not available in traditional formats of therapy, were perceived to enhance the therapists' skill-set. Månsson and colleagues (2013) also reported that providing support and communicating with the client using the digital program was perceived positively by therapists. Similarly, we found that the therapist's use of the digital platform helped to prevent therapeutic drifts, allowed the therapist to keep track of the client's progress and bridge the gap between face-to-face appointments.

Our finding that blended iCBT was perceived as time consuming was also mirrored in other studies, in which the implementation of blended-therapy was perceived as negatively impacting workload, not only by those directly involved in the delivery of the intervention (Månsson et al., 2013) but also non-therapist practitioners within the service (Kivi et al., 2015).

However, we suspect that a range of trial related factors may be responsible for mediating this finding (e.g. research reporting and inflexible structure of intervention within an RCT).

The blended therapy was aimed to be flexible, but at the same time fidelity to treatment had to be standardised in order to assure that the intervention was applied equally by all therapists. It was challenging to keep a balance between the amount of flexibility and standardisation, especially when working across IAPT teams that applied different waiting times, screening methods, number and frequency of therapy sessions etc. It is important to distinguish that many of the challenges reported by the PWPs are directly linked to the impact of research conduct, the RCT methodology and its added burden on both clinical services as well as individual therapists rather than the intervention (the blended approach) per se.

### **Limitations**

The focus groups were relatively small, and each practitioner provided blended therapy to a few clients, which limits the generalisability of the findings. Furthermore, there was a potential conflict of interest as PWPs were participants in the trial, which aimed to evaluate the blended approach the PWPs delivered. This may have also been conceived as an evaluation of their individual abilities to provide therapy; therefore, participants could have been more cautious when discussing challenges and difficulties.

All participants were PWPs whose role is to deliver low-intensity interventions, usually six thirty-minute weekly sessions, mostly on the phone and occasionally face-to-face. The findings of the study may have been different if the practitioners were high intensity therapists who deliver 12 face-to-face sessions as the norm. Having said this, high intensity therapists work with clients who experience severe depression so the nature of blended therapy – as designed for the E-Compared study - would not fit the client demographic being offered high intensity therapy.

Additionally, the interviews were limited to PWPs. The study would have benefited from conducting in-depth interviews with senior staff, who may have played an instrumental role in how the blended intervention was experienced and perceived by practitioners in the study. For instance, one study found that the culture in primary health care services was orientated towards budgetary and cost-cutting objectives as opposed to being guided by evidence-based practices that can positively impact client outcomes. An intervention that is perceived as more time consuming, may therefore be considered as problematic in services that are driven by cost-saving delivery (Kivi et al., 2015). Service leadership may have had more influence on the level of active participation of PWPs in the current trial, and on future research activity.

One-off interviews also meant that it was not possible to capture participants' views at different time points during the trial, when other concerns may have been prominent. This could also have reduced the risk of recall bias in responses.

Finally, our findings apply to the specific UK setting of IAPT services and the specific e-intervention that we utilised. As such, it may not yield strong generalisability in different contexts, but it may however offer some transferability in terms of naturalistic generalisation (Hellström, 2008).

### **Implications for Future Research or Practice**

Understanding what may make blended therapy more burdensome than face-to-face therapy alone, allows designing interventions that can mitigate this 'burden' in routine practice. For example, practitioners can pre-empt client burden due to increased therapy intensity by side-stepping intrusive automated reminders and by filtering through high volumes of information. The burden for practitioners can be overcome through 'slimming down' the intervention or providing more appropriate training to improve familiarity with both the

internet system and the blended approach. Interventions need to be co-designed with practitioners, managers, and clients to ensure a better fit with current practices.

Researchers need to be guided by practitioners and service managers in designing a blended therapy that fits with established clinical practice. For example, the modules of the internet self-help program need to fit the practitioners' training and match the self-help manuals and standardised materials used in routine care. Practitioners also need to have a say on the frequency and length of blended therapy, as well as on the level of intervention (e.g. low vs. high intensity) that is most suited to the service.

### **Conclusions**

This qualitative study provided insights into how practitioners within selected psychological therapy services experience blended therapy and the issues they encounter in the context of limited capacity and established practice norms. Recognising and mitigating certain factors that can turn internet self-help from an added value to an added burden will help practitioners and managers adopt and make the most out of blended therapy. This is important for the successful implementation of internet interventions in routine practice by capacity-limited frontline staff who deliver face-to-face therapy as the established norm.

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## Appendix

### Topic Guides

#### 1. Overview of experience with treatment

- a) What was your experience with the Moodbuster platform?
- b) Can you recall what modules they were? *[To jog memory - optional]*
- c) What was your experience of the blended treatment?
- d) Were there any aspects that you found useful during your work? (Y/N) *Can you tell us what they were?*
- e) Were there any aspect that you found unhelpful during your work? (Y/N) *Can you tell us what they were?*
- f) Do you think this treatment could be improved (further)? (Y/N) *Can you tell me how the treatment can be improved?*

#### 2. Aspects of treatment

*Now, we are interested in learning more about how you experienced different components of treatment.*

- a) **Engagement:** *First we would like to know how you engaged with treatment. Generally, we would define engagement as 'Starting and continuing to work with the intervention'.*

Were clients able to engage with Moodbuster (Y/N) *why did you think they were able / not able to engage with the treatment?*

- Online
- Face-to-face
- Combination

- b) **Informativeness:** What did you think about the information provided in the modules:

- Online
- Face-to-face
- Combination

- c) **Techniques:** What did you think about the techniques provided in the modules?

**d) Friendliness:** Was the program easy to use? (Y/N) *what aspects did you (not) find easy to use?*

- Online
- Face-to-face
- Combination

**1. Effectiveness of treatment:** Did you have confidence that the program you were using would be helpful to clients before using it? (Y/N) *why is this?*

**2. Expectation:** Has your expectations changed after using it? *What has changed for better? / or What views have changed for worse?*

- Online
- Face-to-face
- Combination

**3. Sensitivity:** How sensitive or responsive did you find the:

- Online modules
- Face-to-face
- Combination

**4. Motivation:**

- How motivated were clients to complete the online programs? *What do you think kept them motivated? / What made them less motivated? Was there anything that could have motivated the clients more?*
- How motivated were clients to attend the face-to-face sessions? *What do you think kept them motivated? / What made them less motivated? Is there anything that could have motivated the clients more?*

**5.** Would you suggest MoodBuster to other therapist? Why/Why not?

**6.** What was your experience of participating in a research study? Pros and cons.

**7.** Did study participation affect your usual practice? Did participation add or lower work pressure? How, why?

**8.** What could the research team have done to ease the process? What was done well and what can be improved?

**9.** How do you feel about participating in research studies in the future?

**Authors' Information**

	ACP	AD	JW	LG	RA
<b>Title and credentials</b>	e-Mental health researcher, PhD Trial manager for the E-Compared trial	e-Mental health researcher, PhD-candidate Research assistant on the E-Compared trial	Mental health researcher, PhD	Mental health researcher PhD, Reader Local Principal Investigator for of the E-Compared study in two sites in North England	e-Mental Health specialist Professor, psychiatrist Principal Investigator of the E-Compared study in the UK
<b>Role in focus group research and potential impact on interview conduct and analysis</b>	Had established relationship with PWPs over two years during the conduct of the E-Compared trial. Monitored PWPs recruitment of clients with depression and their treatment fidelity. This relationship was likely to affect the responses of PWPs during the interviews therefore, ACP did not take part during the interviewing process. Compiled the Topic Guides and led the data analysis.	Had established relationship with PWPs over two years during the conduct of the E-Compared trial. Recruited PWPs into E-Compared, and trained them on the blended approach. AD co-facilitated the first focus group with JW, to introduce JW and help her build the relationship with participants. She did not attend the rest of the FGs in order to minimise response bias. Compiled the Topic Guides and supported data analysis.	Recruited exclusively to conduct Focus Groups work to reduce response bias. JW recruited PWPs from the larger pool of E-Compared therapists. She organised and conducted the interviews and supported data analysis.	Led the conduct of E-Compared in north England. Clinical and research expertise on e-interventions for depression and IAPT service delivery.	Led the E-Compared study in the UK, and the research team. Clinical and research expertise on e-interventions for mental health problems and IAPT service practice.

Table 1. *Participant characteristics*

Participant ID	Gender	Age (years)	Number of clients*	Clinical experience	Site	Data collection
1	Male	24	1	1 year	A	Focus Group 1
2	Male	25	3	2 years	A	Focus Group 1
3	Female	26	2	4 years	A	Focus Group 1
4	Female	27	6	4 years	A	Focus Group 1
5	Female	NI	3	NI	A	Focus Group 1
6	Male	28	7	2 years	A	Focus Group 2
7	Female	27	1	2 years	A	Focus Group 2
8	Male	31	11	2.5 years	B	Focus Group 3
9	Male	NI	9	NI	B	Focus Group 3
10	Female	30	3	2.5 years	B	Focus Group 3
11	Female	NI	3	NI	B	Phone interview

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\* with whom the practitioner delivered blended therapy as part of the E-COMPARED study  
 NI- No Information

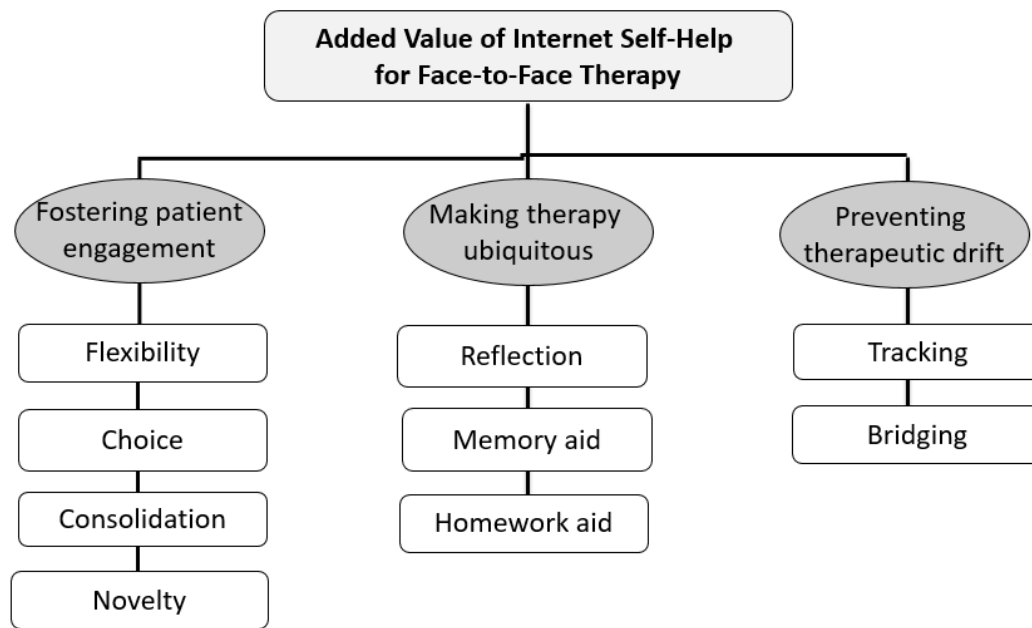


Figure 1. *Practitioner experiences of how internet self-help can add value to face-to-face therapy*



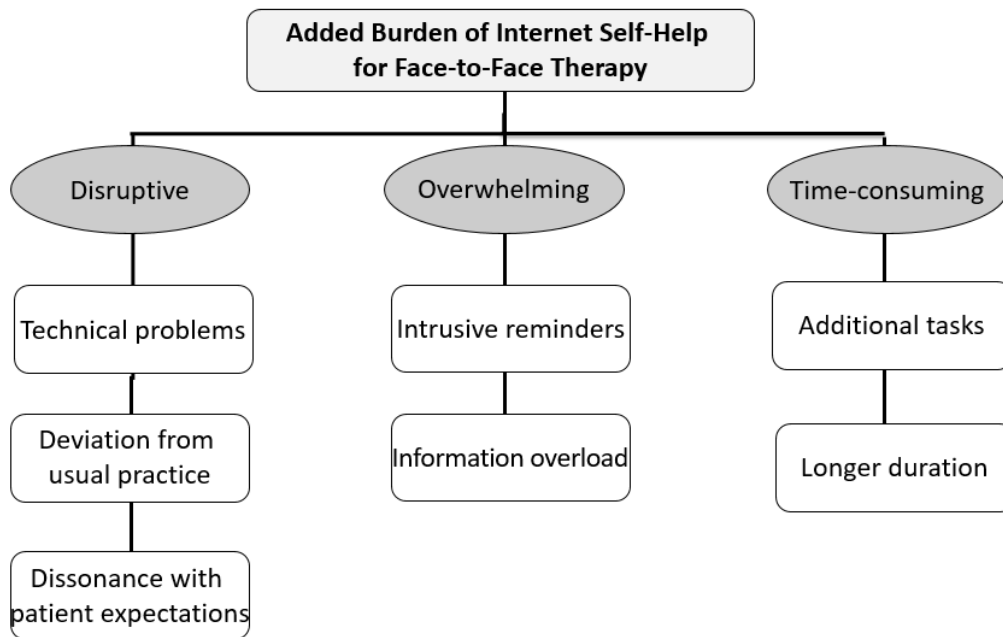


Figure 2. *Practitioner experiences of how internet self-help can become a burden to face-to-face therapy*